MDS CORRECTION POLICY IMPLEMENTED WITH VERSION 1.04 OF THE STANDARD DATA SPECIFICATIONS FOR THE MDS 2.0

Version 1.04 of the MDS data specifications implements a new correction policy. This correction policy allows facilities to correct "prior" MDS assessment or tracking form records. By a "prior" record, we mean a record that has previously been submitted and accepted into the State database. Facilities are now able to either ***modify*** or ***inactivate*** prior records**.** These actions will allow a facility to insure that its data in the State MDS database is accurate.

INACTIVATION OF RECORDS

A facility should inactivate a prior MDS assessment or tracking form record in the State database when the record should not actually have been submitted. This can occur if a test record was inadvertently submitted as a production record. Another example would be if a discharge were submitted for a resident when no discharge actually occurred. Cases necessitating inactivation should be quite rare. However, it is still quite important to be able to correct them.

When a record is inactivated in the State database, it may no longer be used in standard system applications such as resident roster reports, QI reports, and Medicare PPS payment reconciliation. Note that the term "inactivation" is used rather than "deletion." This is because the inactivated record is not actually removed from the database but rather flagged as no longer "active". An inactivated record is still available as part of the history of records submitted by the facility. ***The pattern of inactivations and the impact of those inactivations will be audited for each facility.***

Submitting an Inactivation Request. To request an inactivation, the facility submits a new type of MDS record, an "inactivation request" record. This inactivation request record conforms to the Standard MDS record layout and should be placed in a standard MDS submission file, along with other types of MDS records (assessments, discharge tracking forms, and reentry tracking forms). Two new sections have been added to the standard MDS record layout to accommodate the inactivation request, a "Correction Attestation" section and a "Prior IDs" section.

The **Correction Attestation section** is in the Record Control Area at the front of the MDS record, preceding the standard MDS items (items on the MDS form itself). The fields in the Correction Attestation section provide the authorization for the inactivation request and are labeled as AT1 through AT6 (with the "AT" indicating "attestation"). Among these fields are the reasons for requesting an inactivation, the name of the person attesting to the need for inactivation, and the attestation date. All of the "AT" fields, except for the AT3 fields (reasons for a record modification instead of an inactivation) must be completed on an inactivation request.

The **Prior IDs section** is toward the end of the MDS record, following the standard MDS items (items on the MDS form itself). The fields in this section all begin with a prefix of "PRIOR_" followed by a standard MDS item label (e.g., AA1a, AA1c, AA2, etc.). These fields are the key identification fields for the record to be inactivated. For example, PRIOR_AA1a is the resident first name on the prior record to be inactivated; PRIOR_AA1c, the resident last name; PRIOR_AA2, the resident gender; etc.

The MDS record for an inactivation request is completely described in the "Uniform Data Submission Specifications for the MDS 2.0 (1/30/98): Data Record Layout for Submission from the Nursing Home to the State (Version 1.04)". Please consult that document for full details. Briefly, an inactivation request record has the following characteristics:

a) Most fields in the REC_CONTROL (Record Control) section (before the standard MDS items) must be completed, including the following:
    i) The REC_ID field must be "X0" (the "X" indicating an inactivation request, followed by the number "zero").
    ii) The FAC_ID field must contain the standard MDS system facility ID, as assigned by the State.
b) All standard MDS items from MDS sections AA through V must be blank.
c) Several fields in the OTHER_INFO (Other Information) section (following the standard MDS items) must be completed. These fields are contained in the PRIOR_IDS fields (from PRIOR_AA1a through PRIOR_A3b).

If these specifications are violated, then the inactivation request ***will be rejected***. Note that all standard MDS items are ***blank*** in a record for an inactivation request. This is intended to emphasize the fact that an inactivation request includes no "new" data. Rather it simply includes the information to identify the prior record to be inactivated and the justification for the inactivation.

MODIFICATION OF RECORDS

A facility should modify a prior MDS assessment or tracking form record in the State database when the record is known to have data errors. Data errors can occur for a variety of reasons, including transcription errors, data entry errors, or software product generated errors. It is important to correct such errors to achieve an accurate view of the facility's residents in the State database.

When a record is modified in the State database, two events actually occur: (1) the prior record in error is located and inactivated and (2) a new, corrected record is placed in the database. Standard State system applications such as resident roster reports, QI reports, and Medicare PPS payment reconciliation may then use the corrected record and ignore the inactivated record. Note that the prior, inactivated record is not actually removed from the database but rather flagged as no longer "active". A record inactivated by a

modification request is still available as part of the history of records submitted by the facility. ***The pattern of modifications and the impact of those modifications will be audited for each facility.***

Submitting a Modification Request. To request a modification, the facility submits a new type of MDS record, a "modification request" record. This modification request record conforms to the Standard MDS record layout and should be placed in a standard MDS submission file, along with other types of MDS records (assessments, discharge tracking forms, and reentry tracking forms). It includes a corrected MDS record (assessment, discharge, or reentry) with all of the appropriate data fields present and correct. ***Note that the modification request includes all of the appropriate data fields for the corrected MDS record, not just the fields being corrected.*** Upon receipt by the standard State system, the corrected record will be validated using the standard edits. In most cases where a validation error occurs, the modification request will be rejected.

A modification request also includes the "Correction Attestation" section and the "Prior IDs" section (these new sections of the MDS record have been described above). The fields in the Correction Attestation section provide the authorization for the modification request, and the fields in the Prior IDs section are the key identification fields for the prior record in error. Note that a record corresponding to these prior IDs must already exist in the State database. If not, the modification request will be rejected.

The MDS record for a modification request is completely described in the "Uniform Data Submission Specifications for the MDS 2.0 (1/30/98): Data Record Layout for Submission from the Nursing Home to the State (Version 1.04)". Please consult that document for full details. Briefly, a modification request record has the following characteristics:

a) Most fields in the REC_CONTROL (Record Control) section (before the standard MDS items) must be completed, including the following:
    i) The REC_ID field must be "M0" (the "M" indicating a modification request, followed by the number "zero").
    ii) The REC_TYPE field must be that appropriate to the new, corrected MDS record. (The REC_TYPE may be different from the REC_TYPE in the prior record.)
    iii) The FAC_ID field must contain the standard MDS system facility ID, as assigned by the State.
b) All standard MDS items from MDS sections AA through V must be present, these items describing the new, corrected record.
c) The MDS correction number (A3b) must be greater than zero.
d) Several fields in the OTHER_INFO (Other Information) section (following the standard MDS items) must be completed. These fields are contained in the PRIOR_IDS fields (from PRIOR_AA1a through PRIOR_A3b).

e) When the modification request is received by the State, an existing MDS record corresponding to the Prior IDs must already be present in the State database.

If these specifications are violated, then the modification request ***will be rejected***. Recall that the standard MDS items are ***present*** in a record for a modification request. These standard MDS items reflect the new, corrected record and these items will be validated using the edits for an ordinary MDS record. In most cases where a validation error occurs, the modification request will be rejected.

Please note that a modification request can be used to correct any MDS items, whether the items are "key" identification items or "data" items. This feature differs from previous State and demonstration project systems that have required different types of requests for key changes versus data amendments. The modification request always includes all of the data for the corrected record and the key items used to identify the prior record which contains the error. It is not necessary for the facility to distinguish between key change and data amendment requests or to tag the specific amended items.

The new modification request is quite flexible and will even allow the facility to easily change the type of record. For example, the facility may have inadvertently submitted a reentry form instead of a discharge. A single modification request will fix this situation. That modification request would include all of the appropriate items for a "new" discharge record and the IDs for the prior reentry record. If accepted, the modification request would inactivate the prior reentry and add the "new" discharge to the database. This process will allow any type of correction, even changing a quarterly assessment to a comprehensive assessment. Note, however, that the modification request must always include ***all of the appropriate data for the new, corrected record***.

The new modification request also replaces the prior "manual" process for making MDS key corrections. Under this manual process, the facility was required to notify the State if there were key fields in error, and then State staff would have to manually locate and correct the record in the State database. This manual process was quite cumbersome and resource intensive for both the facility and the State. With the new process, when a facility detects key errors, a modification request is submitted through the normal MDS submission process, and the State need not make any manual changes.

The data modification process in no way precludes the need for "significant change" assessments. The data modification process is used to make corrections to insure that the data in the State database matches the actual assessed condition of the resident at the time of assessment (e.g., assessment reference date in item A3a). If the resident's condition has changed since that time, a data modification is completely inappropriate for reporting this change. Rather, when a resident has experienced a significant change in condition, a new "significant change" assessment must be performed, involving new observation of the resident, a new assessment reference date, and appropriate changes to the resident's care plan. A data modification for an assessment is a request to correct an existing record and does not involve a new assessment with a new observation period. It cannot be used to record changes to a resident's condition. It cannot substitute for a significant change assessment. To do so would jeopardize the clinical integrity of the MDS process.

Similarly, the data modification process in no way precludes the need for "significant correction" assessments. If the resident's condition has been clinically mis-assessed, then the facility should review the situation and determine if the error is major. If the error is major (e.g., an inappropriate care plan has resulted), a new "significant correction" assessment must be performed, involving new observation of the resident, a new assessment reference date, and appropriate changes to the resident's care plan. A data modification cannot be used in lieu of this clinical correction process. If there are data errors in the prior assessment record in the State database, then both a modification request to the prior record and a new significant correction assessment may be appropriate. However, a data modification cannot simply substitute for a significant correction assessment. To do so would jeopardize the clinical integrity of the MDS process.